UTAH LABOR COMMISSION

WORKERS' COMPENSATION HANDBOOK FOR PHYSICIANS

Updated October 15, 2005

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In cooperation with the
Utah Labor Commission

This Workers' Compensation Handbook for Physicians booklet is designed to assist providers in their relations with the Utah Labor Commission. The information has been reviewed and approved by the Utah Labor Commission.

(Updated as of October 15, 2005)

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I Introduction

A. The Workers' Compensation Program.

The workers' compensation program is a state program. Each of the 50 states initiated and adopted such programs in the early 1900's. Utah's workers' compensation program became law in 1917. Federal employees are not covered under state workers' compensation program.

Utah's program provides medical benefits and replacement of lost earnings at 66 and 2/3rds percent of weekly salary while a worker, due to an industrial injury or illness, is temporarily totally disabled. The system is a "no fault" system in that negligence does not have to be established by a worker or employer in order to receive benefits. The system was designed to provide a speedy remedy to an injured worker so that sustenance would continue while medical recovery took place and families would then, not be put in a hardship or onto welfare rolls. The employer enjoys the "exclusive remedy" provision in that an employee who is injured on the job may not sue their employer.

The workers' compensation program in Utah is a mandatory program. Every employer in Utah with even one part-time employee must have coverage, except for some exemptions for agriculture and domestic workers. Employers may insure their workers' compensation liability in one of 3 days: 1) with a private insurance carrier; 2) with the Workers' Compensation Fund of Utah; or 3) by applying with the Labor Commission for the privilege of self-insuring. The Workers' Compensation Fund of Utah is now a quasi-governmental agency. The Fund is <u>not</u> a part of the Labor Commission. It bears the same relationship to the Commission as do private insurance carriers and the self-insured employers.

B. Administration of the Workers' Compensation Program

The Division of Industrial Accidents, Labor Commission of Utah, has the responsibility of administering the workers' compensation program. The Division's responsibilities are:

1) Bringing uninsured employers into compliance of providing workers' compensation insurance for their employees;
2) Monitoring the reporting of injuries by employers and physicians;
3) Providing information and resolving problems with injured employees, providers, insurance carriers and employers;
4) Tracking claims to ensure promptness and fairness of payment;
5) Writing the rules in clarifying the statute governing workers' compensation;
6) Assisting injured workers in getting medical bills paid;
7) Coordinating efforts to return the injured worker to the work force; and
8) Administering the self-insurance program.

The Labor Commission of Utah is always willing to provide whatever assistance it can. If the provider has questions or problems, he/she should feel

free to contact the Utah Labor Commission for information regarding the process or problem. It is essential to bill the correct insurance carrier for payment. The Labor Commission pays no medical bills and does not have sufficient staff to sort through medical bills that are sent to the Commission. Therefore, all medical bills sent to the Commission are discarded. Workers' compensation does not encompass the unlimited field of personal injury or disability and the jurisdiction of the Labor Commission is strictly limited by statute to apply to only work related injuries/illnesses.

C. Eligibility for Workers' Compensation

In order for an employee to be eligible for medical care under the Workers' Compensation Act, four essential elements must exist. They are:

1) The employer must be subject to the Act;
2) There must be an employer-employee relationship;
3) The injury, illness, or death must qualify as compensable under the Act or case law in existence; and
4) Notice of the industrial injury must have been given to the employer or Labor Commission within six (6) months of the date of injury or knowledge of (diagnosis) an occupational disease. An application for death benefits must be filed within one (1) year after the date of death.

There is no guarantee to the provider that the industrial insurance carrier will assume liability for the bills presented by the provider. In cases where the employer either has no workers' compensation insurance, or if the insurance carrier denies payment, the provider should bill the patient. It is then up to the injured/ill employee to apply for a hearing before the Labor Commission to resolve the issue. If the injured employee worked for an uninsured employer who is insolvent or bankrupt, the Uninsured Employers Fund becomes responsible for the medical bills when the injury/illness is compensable. If the Labor Commission rules the injury/illness is not work related, the provider should seek payment from the patient and readjust the bill to the "usual and customary" level. The employee can then present the bill to a group of personal insurance carriers for payment. Since some health insurance policies with a contract with an HMO or a PPO limit the choice of providers, the employee should follow the rules of the health insurance carrier in order to assure payment of the bill. Employees of those employers who specify a company doctor for work-related cases should discuss medical care with their employer before seeking medical treatment.

Questions regarding medical care in specific cases should be discussed promptly with the insurance carrier.

Other questions concerning rules, reporting, fees, or payment disputes should be directed to the Division of Industrial Accidents (530-6800). Most problems are due to misunderstandings, misinterpretations or lack of knowledge or communication. The Division of Industrial Accidents staff is most willing to help all parties in solving problems.

II. Medical Care for Workers' Compensation

An injured employee is entitled, without personal expense, to medical care treatment and hospitalization reasonably necessary, up to the limits prescribed by the law. The provider should always bear in mind that the carrier must make his/her decision based on the information provided by the provider. If the provider has not sufficiently documented the treatment given and the reasons for that treatment, the adjuster may consider such treatment unreasonable or unnecessary.

It is the prerogative of the attending physician to determine the type, duration and frequency of treatment, including hospitalization and nursing services. Such services must be provided in accordance with recognized professional standards for the type of injuries incurred. Services in addition to those prescribed or ordered by the attending physician must be paid for by the patient.

A. Physician Selection

The employer has the right to select an attending physician for medical care related to an industrial injury or illness. If an employer, or the employer's insurance carrier, has designated a physician or clinic for medical care for work-related injuries/illnesses, the employee must first seek treatment through the employer-designated medical provider. If the employer or the employer's insurance carrier does not designate a medical provider, the employee is free to select a physician. Once the injured employee has been seen by the employer's designated medical provider, the employee can make one change of physician without the approval of the employer or its insurance carrier with prompt notification of the change to the insurance carrier.

The Utah Legislature passed a Managed Health Care Bill in 1992 for workers' compensation which took effect January 1, 1993. The Managed Health Care Bill allows insurance companies and self-insured employers to develop a preferred-provider program which requires the employee to utilize the preferred-provider physicians and medical care facilities. Failure to initially use the preferred physician by the industrially injured/ill employee, who has been informed of the program, can result in the employee being obligated for any charges in excess of the preferred-provider allowances.

The bill also authorized peer review, utilization review, use of case management, and bill audits. It, therefore, becomes very important in all but non-emergency cases, that **before providing any extensive services, a provider check with the insurance carrier for those procedures requiring pre-authorization.**

The confidence of the patient in the ability of his/her physician is an important element in the treatment of an injury/illness. When an injured/ill employee is referred to a physician unknown to him/her, it is the duty and responsibility of the physician to dispel any doubt or uncertainty by a quick response to the needs of the patient and by obtaining the patient's confidence and cooperation. Most patients, whether they state it or not, rely upon the provider to guide them

through this difficult time and deal with a type of insurance that may be entirely new to them.

There are some rules in place to prevent the patient from "doctor shopping" (changing doctors time and time again until the patient obtains a diagnosis that he/she agrees with or running up unnecessary charges for duplicative services). The insurance carrier or self-insured employer has control over changes of doctor with some exceptions:

1. Emergency Room Care – Not all industrially-injured patients who present themselves to the emergency room are in need of "emergency treatment." They should be advised that, if the employer has a designated physician, they could encounter problems if they have not seen that physician first, even if it means a wait until the next day. If the patient is made aware of this, the patient may still choose to be, and should be, treated. Once treated, however, they should make arrangements to be seen by the employer's designated physician. Of course, the patient who is brought in by ambulance MUST be treated in the emergency room. If the choice for initial care is the emergency room, the injured employee may change the care to a private physician with prompt notification provided to the insurance carrier. ONCE THE PATIENT HAS CHANGED HIS/HER PHYSICIAN TO A PRIVATE PHYSICIAN, HE/SHE MAY NOT RETURN FOR ADDITIONAL EMERGENCY ROOM TREATMENT, EXCEPT AT THE DIRECTION OF THE TREATING PHYSICIAN OR IN INSTANCES WHERE LIFE OR LIMB IS THREATENED.

The employee may make one change of doctors, not counting the change from the emergency room, unless the emergency room is named as the employer's physician, without requesting permission of the insurance carrier, provided the carrier is promptly notified of the change of doctors.

The insurance carrier is to provide the industrially-injured/ill patient with a copy of the change of doctor rules. However, the physician is often the first party to be aware of the injury/illness, and therefore, a copy of the change of doctor rules has been included at the end of this booklet which may be helpful to the patient, if made available by the physician.

There are several reasons for controlling a change of doctors. Certainly good medical management would dictate that the patient not be seen by one physician after another, each in turn not being apprised of the other's treatment. Cost containment is another factor. There is no reason for the same x-rays, tests and diagnostic examinations to be taken by a series of doctors. If a change of doctor is controlled, medical records, diagnostic reports and x-rays can be transferred from one physician to another, each benefiting from the groundwork done by the previous physician, and the carrier will not have to pay for the same test or x-ray over and over again. Thirdly, there is the question of medication. There are some employees who would use the industrial system to gain access to any number of treating physicians for the purpose of having addictive drugs prescribed. While each physician seeing the

patient may be very conservative in providing such, in the aggregate, they may all add up to a disaster.

The patient can be under the care of only one physician, designated as the **Treating Physician**. Other specialists may assist or participate in the management, if required by the case, while the patient continues under the management of the **Treating Physician**. No care should be duplicated.

No industrial patient is to be simultaneously treated by more than one physician without prior approval or one of the following circumstances being present:

1. Emergency care is such that several physicians' care is required to deal with multiple injuries;
2. Injuries received require multiple areas of medical specialty, such as:
   a) an eye injury and a broken limb;
   b) injuries to the teeth and lacerations of the trunk; or
   c) brain injuries and internal injuries.
3. Surgery or routine care require the use of a radiologist, laboratory services, and/or anesthesiologist, as outlined in the currently-used coding procedures. A physician who feels that simultaneous treatment by two physicians is needed should contact the carrier to discuss the matter.

B. Referrals

1. Referrals to other physicians by the Treating Physician or carrier are not considered a change of doctors for the employee. The referral should be done in writing, with a report to the insurance carrier stating the reason for it. Medical records, diagnostic reports, and x-rays should be transferred with the patient in order to avoid duplication of services. Referrals should <u>not</u> be made to a physician or medical facility outside the state of Utah without prior approval by the insurance carrier, unless the employee is moving out of state. If the injured employee is moving out of state, the employee must complete forms and file them with the Utah Labor Commission. The Treating Physician will be asked to complete a report documenting the employee's condition at the last examination.

2. It should be clearly indicated if it is to be a consultation, second opinion, referral for treatment of associated problems outside the skill of the treating physician, or an impairment rating, or for some other purpose.

   Patients thus seen should generally not have any treatments initiated unless the referral is clearly for that purpose in the minds of the Treating Physician and the insurance carrier. The case may be transferred from one physician to a physician of more expertise in the problem by the attending physician. The insurance carrier should be notified. Physicians to whom a patient is referred should make every effort to obtain the necessary results of prior studies of all kinds to

minimize costly duplication. The length, extent and complexity of the report should be consistent with the needs indicated in the request. The report should not be more lengthy or complex than required to convey the necessary information accurately.

3. If a request so specifies, the physician can become the Treating Physician. Another physician may be requested to perform certain studies or procedures without a transfer or becoming the Treating Physician.

   Physicians, surgeons and practitioners are prohibited from performing work for which they are not qualified. Payment will not be allowed for any services. When the nature or complexity of the case so indicates, transferring to appropriate specialists at the earliest possible time should be carried out.

4. In all cases where there is a serious eye injury or any likelihood of complications arising or permanent visual impairment resulting, the case must be referred immediately to a specialist.

C. Consultations

1. Consultation can be called on at any time and appropriate usage is encouraged. Generally, the Treating Physician should be notified. It is not necessary to obtain permission from the carrier, but the appropriate parties should be notified in writing.

2. Treatment should be undertaken only under special circumstances and with agreement of the parties concerned advised. It is of paramount importance that there always be a clear identification by all parties as to who is the "Treating Physician." Do not assume the care of the patient without a clear mutual understanding and agreement.

3. Consultants are duty-bound to file identical reports with the carrier and the attending physician. Reports beyond the "Physicians Initial Report of Injury or Occupational Disease" (Form 123), the final report and billing are not required by the Labor Commission, but are appreciated. Reports of consultants should include the following information:
   - The date and place of examination
   - The patient's history of injury and development to date including work status since injury and time of examination
   - The patient's past history, insofar as the past history will affect the doctor's opinion of the patient's condition
   - The examination findings
   - X-ray and/or laboratory findings
   - Diagnosis and opinion

4. **Consultation, Usual (RBRVS Codes 99241-99263)**

A consultation is a service provided by a physician whose opinion or advice regarding evaluation as to diagnosis and/or management of a specific problem is requested by another physician or other appropriate source.

5. **Confirmatory Consultations (RBRVS Codes 99271-99275)**
The consulting physician provides evaluation and management services when aware of the confirmatory nature of the opinion sought. Only advise and/or opinion should be rendered. Treatment should not be undertaken.

6. Carriers and self-insured employers may request the services of a physician to do a medical examination of an industrially-injured patient. The cost incurred therein is to be billed directly to the carrier/employer requesting such service.

D. Special Medical Evaluation (in the past referred to as IME)

1. The requesting of services by a physician because of the physician's special level of competency. These evaluations are generally not to include more than one visit, unless additional time, or special testing procedures, is needed to complete the evaluation. The Treating Physician should be notified and, generally, treatment by the evaluating physician is not to be undertaken.

2. Fees are to be arranged in advance with the person requesting the services clearly defining the scope of the evaluation and information needed in the written report.

F. Dentist

1. Except in rendering first aid in a case of emergency, a licensed dentist must obtain authorization from the carrier or self-insured employer before performing any services.

2. The dentist must outline the injuries received, the plan for reconstruction and/or treatment, and a listing of the costs for performing those services. The carrier or self-insured employer should promptly respond with either a denial of liability or an acceptance, designating the dollar amount approved. At that point, the dentist must either accept the amount designated by the carrier/employer, reach a compromise agreement with the carrier, or notify the carrier that he/she is not willing to do the work for that amount.

3. It would then be up to the injured worker to decide whether or not he/she wants to see another dentist or wishes to assume the difference at his/her own expense. If the injured worker does not want to, or cannot assume the difference in cost, it would be the responsibility of the carrier to provide the patient with a dentist who would do the work for the payment indicated.

G. Hospital or Surgery Pre-authorization Procedures

Pre-authorization is required for many procedures and shall be made in writing utilizing the Form 223 (found in the back of this manual). Within five working days of a request for pre-authorization, the employer/carrier shall notify the physician and employee of approval or denial of the procedure. The employer/carrier shall have five days from receipt of the request to notify the physician and employee of their decision. If the procedure is denied, the carrier representative is to disclose the criteria utilized along with the responsible party denying the request. The provider is then able to resubmit a request to the carrier requesting a physician review. A disposition for this second request is to be concluded within 5 days and is to be forwarded to the Commission. The request can only be denied after a physician-to-physician dialog has occurred. If denial still occurs, the request can be submitted to the Commission for an independent binding, medical review, arbitration, or adjudication. If the physician proceeds with the requested procedure without pre-authorization, the injured worker may be personally responsible for the bills incurred and may not be reimbursed for the time lost, unless a determination is made in injured workers' favor (See Rule R612-2-26). If a determination of liability is made for the injured worker, and pre-authorization was not obtained, the physician's reimbursement can be reduced to 50% of the contracted or RBRVS fee.

Discharge from the hospital, or transfer to a facility of a lesser nature, should be done at the earliest time appropriate to good medical practice. Extended care facilities should be utilized when necessary. In most cases, arrangements should be made with the carrier for home care. Payment for hospital care is limited to the ward rate or comparable. If the patient requests a more private hospital accommodation without medical documentation of need, he/she will be responsible for the difference personally. The physician can also use special hospital units, such as intensive care, to the extent necessary. Special nursing care is rarely required, due to the intensive or critical care units in hospitals, but can be utilized if necessary.

H. Vocational Rehabilitation

The attending physician has the best opportunity and the primary responsibility to aid the injured employee in rehabilitation.

The Injured Workers' Reemployment Act of 1990 mandates that the insurance carrier or self-insured employer provide the injured employee with a reemployment assessment after 90 days of temporary total disability.

All assessments hinge upon the physician's assessment of the functional and physical capacity of the injured employee returning to the work force. A return to light-duty is highly encouraged with the physician assigning physical restrictions as needed. The physician should communicate with the patient's employer on the employee's duties and the ability to return to work in the employee's regular job with some restrictions to work in the employee's regular job or other work with the employer.

In case of more serious injury where permanent impairment may result, the attending physician should make recommendations to the employee, the insurance carrier, the employer, and the rehabilitation agency involved, as early as possible, with regard to the advisability of rehabilitation – both physical and occupational – so that the permanent impairment is reduced to a minimum. When it appears that the injured worker will not be able to return to his/her usual occupation, the physician should immediately contact the insurance adjuster, so that training can begin while the employee is still receiving temporary total and/or permanent partial benefits, if physically possible. There is no provision in the current workers' compensation rules for payment of benefits for rehabilitation/training beyond medical stability. The longer a patient is off work, the less likely it is that he/she will ever return to gainful employment

I. Prosthesis

The insurance carrier is required by law to furnish the injured employee with prosthesis, when the prosthesis is reasonable and necessary. This is a life-long obligation of the insurance carrier if the injury is compensable. The attending physician should assist in the selection of the most suitable device and in the training of its use. The carrier has choice of provider and the option of negotiation rates where feasible.

III. COMPENSATION BENEFITS

A. Temporary Total Disability

Temporary Total Disability benefits are payable to an industrially injured/ill worker when the injury/illness caused loss of work exceeding three (3) days. The first three (3) days are compensable if the worker is totally disabled for more than fourteen (14) days. The three (3) day waiting period need not be concurrent or immediately following the injury.

Employees are eligible for 66-2/3% of their gross weekly wage plus $5.00 for the spouse and $5.00 for each dependent up to 4 dependents under the age of 18 years, not to exceed 100% of the state's average weekly wage at the time of injury.

Temporary Total Disability will continue until the injured worker has reached Maximum Medical Improvement (MMI), (up to the maximum benefit entitlement) in the opinion of the physician, or until the physician has released the injured worker to return to work. It is not necessary that the injured worker is capable of returning to his/her prior job. When the patient is capable of performing any remunerative employment, the attending physician is to notify the insurance carrier or self-insured employer within 5 calendar days. The Commission provides "Release to Return to Work" forms, but the physician can indicate the release to return to work on the progress notes sent to the carrier, in letter form or by providing a copy of office notes.

The insurance carrier/self-insured employer has need of knowing the length of time the physician anticipates the injured worker will need off from work for medical reasons for workers compensation disability. The treating physician's reporting of progress and/or continued disability to work is extremely important. If the physician fails to make progress reports, the employee's compensation will, in all likelihood, be stopped. (Also, sending the written progress notes reduces phone calls from adjusters to the physician.)

B. Temporary Partial Disability

Temporary Partial Disability is when a worker is sufficiently recovered so as to be able to do part-time or light duty work (on a temporary basis, with the expectation that he/she will return to regular full-time employment). In these cases, the physicians should clearly state in their reports which duties the injured worker customarily performed in his/her employment that should be avoided and delineate any restrictions.

C. Permanent Partial Impairment Benefits

1. Permanent Partial Impairment benefits are paid due to permanent loss of body function and are divided into two types:
   (a) **Scheduled Injuries** Those injuries to the lower or upper extremities, ears and eyes that can be objectively rated based upon comparison between member or organ. "Utah's 2002 Impairment Guides," or the American Medical Association's "Guides to the Evaluation of Permanent Impairment," Fifth Edition, should be referred to in making these ratings.
   (b) **Non-scheduled Injuries** There are some portions of the body where comparisons cannot be made. Generally speaking, these would include injuries to the torso and head. Many of the ratings of the nervous system would likewise not lend themselves to schedules and thus the condition of the person expressed as a percentage of loss of body function of the "Whole Person" ratings are then applied by the carriers to the 312 week maximum in order to obtain a correlating dollar value.

2. Impairment Ratings must be accompanied by a report of physical findings and should be as specific as possible. If a finger has been injured, the Impairment Rating of the finger, rather than the hand, upper extremity or whole person must be stated, since the Labor Commission will require that the carrier draw up a compensation agreement using the most specific impairment rating.

3. The following charts should illustrate how much difference can be encountered in compensation depending upon the portion of the body the rating is based.

   Exampled #1
   35% Impairment of the Index Finger = 14.70 Weeks

9% Impairment of the Hand	= 15.12 Weeks
8% Impairment of the Upper Extremity	= 14.96 Weeks
5% Impairment of the Whole Person	= 15.60 Weeks

Example #2

3% Impairment of the Index Finger	= 1.26 Weeks
1% Impairment of the Hand	= 1.68 Weeks
1% Impairment of the Upper Extremity	= 1.87 Weeks
1% Impairment of the Whole Person	= 3.12 Weeks

4. The rating of the physical impairment should be related to the most distal level in the Schedule that encompasses all of the impairment. This is the figure the rating is made on. It can then progress up the ladder to whole person.

5. There are specific code numbers and relative values in the RBRVS that are to be used for impairment rating services. Codes 99453 and 99456 are to be used by physicians on the visit when stability is declared. These codes are to be used alone and include the concurrent evaluation and management services on that day.

D. Permanent Total Disability

Certain injuries or losses automatically fall into this category. The loss of two hands, two feet, two arms, two legs, the eyesight in both eyes, or a combination thereof, makes a worker eligible for Permanent Total Disability benefits. Others may qualify for Permanent Total Disability benefits either due to physical impairment or a combination of physical impairment and other disability factors, such as age and education. Each case is evaluated individually, according to the guidelines set by the Workers' Compensation Act.

E. Death Benefits

The following death benefits are provided for under the Workers' Compensation Act:

1. **Compensation** Compensation benefits are paid to the dependents of the deceased. Normally benefits are paid for six (6) years after the date of death (this can be extended by an Administrative Law Judge for dependent spouses and children under 18 years of age). The dependents have one (1) year after the date of death in which to apply for death benefits.
2. **Burial Expenses** These benefits change from time-to-time. The average burial cost is set by the Commission.

IV. PERMANENT PHYSICAL IMPAIRMENT RATING

A. The attending physician should rate permanent physical impairment when he/she believes that the condition of the patient has reached essentially a permanent and stationary condition and when, for all practical purposes, the

patient has reached Maximum Medical Improvement (MMI). In the event the physician either wishes not to, or may not feel qualified to, give a permanent physical rating, the patient should be referred to a qualified physician for rating purposes.

B. The rating of permanent physical impairment is a function of the physician. The residuals following an industrial injury or occupational disease are rated as to the physical impairment based upon the specific loss of function of the part of the body involved or the body as a whole. This is done without an attempt to measure and without consideration of a relationship to the social aspects of the disorder or the employee. In order to maintain as much consistency in rating as possible, the Labor Commission of Utah currently requires the use of the "Utah 2002 Impairment Guides" for all ratings of impairment given after July 1, 2002 as per Rule R612-6. The American Medical Association Fifth Edition of *"Guides to the Evaluation of Permanent Impairment"* is to be used in determining impairment ratings only if the rating cannot be found in the "Utah 2002 Impairment Guides." If the examiner does give a rating that is not in conformity with this Utah Guide, the report must include the basis for this judgment clearly stated in the report to appraise those persons acting on this information, so they will have a more clear understanding of the pathological condition being considered. This should rarely occur.

C. The Workers' Compensation Act specifies specific weeks of compensation for specific anatomical losses. For this reason, the rating physician should rate the body part affected that will encompass all of the impairment. If more than one extremity or organ system or the spine is involved, it is necessary to give the rating in percentage of loss of whole body function. This is done by using the proper tables to arrive at each loss in terms of the body as a whole and then these are combined using the Combined Values Chart. (Please refer to "Utah's 2002 Impairment Guides.")

D. A physician needs to study the Utah Guides and be knowledgeable as to the proper methods of assignment of impairment and the utilization of the Tables included. If a physician does not know how to properly assess permanent impairment, it is much better that no opinion be given because this frequently leads to significant problems.

E. The report need only include the pertinent facts of the case – stabilization, the examination findings on which the rating is based, and the rating estimate. Please refer to "Utah's 2002 Impairment Guides" for full information.

V. REQUIRED MEDICAL FINDINGS

The character of the workers' compensation system gives rise to the necessity for medical reports. The system cannot operate without them. Prompt and complete reports enable carriers to pay benefits speedily and without interruption when due. Conversely, if the carrier does not receive prompt and periodic reports, compensation can be delayed or interrupted. Such economic loss on top of the physical, and often emotional trauma already incurred, can result in extensive personal and financial

problems for the patient and can negatively impact the healing and rehabilitation process.

The following are required reports from physicians:

A. The "Physician's Initial Report of Injury or Occupational Disease" (Form 123)

This is the initial medical report filed. This form is to be distributed to the following: The Labor Commission of Utah, the insurance carrier, the injured worker and a copy for the physician's records. It is to be filed within one (1) week of the initial visit. It is of special importance that the employee's description of the accident/illness be recorded accurately and completely. In fact, the employee could complete that portion personally. All complaints should be documented, so as to make those injuries part of the record. Examinations and the findings, as well as the specific treatment provided, should be complete to substantiate the level of service billed for by the physician. No payment will be made to the injured employee until a medical report stating definite compensable loss is received. This form is often used by the insurance carrier to set up reserves adequate to cover the complete treatment of the case. Therefore, as much pertinent information as possible should be given. However, it is not intended that the opinion provided by the physician on this form be set in concrete. A statement that permanent impairment is unlikely can be revised at any time that such impairment becomes evident. Likewise, periods of Temporary Total Disability can be extended or shortened, and subsequently discovered preexisting problems reported at any time. Note: Most carriers and physicians now have fax machines. Physicians are encouraged to fax report to the carriers.

B. "Restorative Services Authorization/Denial" (Form 221)

Rule R612-2-3(b), effective on October 31, 1995, and updated June 1, 1998, and April 22, 2003, requires that all providers who bill under the Restorative Services Section of the Medical Fee Guidelines, submit the Restorative Services Authorization Form (Form 221), in addition to the "Physician's Initial Report of Injury" Form (Form 123) and S.O.A.P notes. The rule and form are in the back of this handbook.

C. "Authorization Request for Medical Procedures" (Form 223)

This is a form used when a medical provider is requesting authorization for payment of a medical procedure. The request form needs to be submitted to the insurance carrier for procedures other than office visits, standard x-rays and emergency care. The form does not apply to restorative services except when a request for additional treatments have been denied and the physician desires a review by another physician.

D. Progress Reports/S.O.A.P. Notes

Some individual carriers may have forms they prefer to use in their cases. If so, they are responsible for providing them to the physician. The Commission does not have a form for this purpose and accepts typewritten narratives in letter, or progress notes form, or photocopies of case notes or progress notes. What is important is not the form but the content. LEGIBILITY IS OF

PRIME IMPORTANCE, The carrier should be updated as to the progress, improvement, complications, expected release dates, considered treatment, etc., as the patient is treated. These should be provided by the physician automatically and should not require repeated requests by the carrier. Failure to provide these progress notes can result in the patient's benefits being stopped and the physician's bill not being paid.

In addition, it should be reported to the carrier when patients are sent to consulting physicians. The reports of the consulting physicians also need to be sent to the carrier/employer. Referrals, when made, should be documented in writing and medical records, reports and x-rays should be transferred to the new treating physician.

E. "Release to Return to Work" (Form 110)

This form, which is provided by the Labor Commission, is completed by the physician at the time the physician releases an employee to return to work (with either a full release or a light-duty status). This form must be transmitted to the carrier/employer within five calendar days (not working days) of such visit. If the physician cannot meet that deadline, he should place a call to the carrier and either inform the adjuster that the employee has been released to return to work or leave a message to that effect. The physician may note the release to return to work in a progress note, but this must be sent to the insurance carrier immediately.

When services are rendered by more than one physician, or by a physician and a therapist, each must separately report, fully describing the conditions found and the treatment given.

F. General Recommendations

It should be mentioned that occasionally the attending physician may observe in a patient a reluctance or refusal to cooperate with physicians in their efforts to effect a speedy and complete recovery from the injury. Proper administration of the statute compels physicians to make special, detailed reports in case of uncooperative patients. It is the carrier/employer duty to provide such medical treatment as needed to return the injured employee, as nearly as possible to the same condition as experienced prior to the industrial injury. If lack of cooperation on the part of the patient results in longer or more expensive treatment, such should be reported promptly. In such case, the physician should indicate what additional treatment is necessitated by the patient's lack of cooperation or failure to follow directions.

G. "Attending Physician's Statement" and Employee's Notification of Intent to Leave Locality or State and Change Doctor or Hospital" (Forms 043 and 044)

For the protection of the patient and for the knowledgeable management of the case by the carrier, the employee must file an "Employee's Notification of Intent to Leave Locality" with the Utah Labor Commission and supply the physician with an "Attending Physician's Statement" form to complete for the Labor Commission. This statement includes the attending physician's certification that such a move is medically acceptable and includes the

physician's assessment of the patient's condition upon last examination. Upon receipt of both forms, the Commission mails copies of the forms to all parties, including the new treating physician, if know.

V. MEDICAL FEES

A. The Labor Commission's Relative Value Fee Schedule (RBRVS)

1. Fees in all cases must conform to the most recent Resource Based Relative Value Schedule (RBRVS). Providers are paid for services to injured employees by the carrier or self-insured employer according to the RBRVS adopted by the Utah Labor Commission. The commission has statutory authority to fix fees for medical treatment for industrial injuries and, for this reason, cannot legally accept a "customary charge" concept. Services by licensed practitioners are subject to the RBRVS and the associated rules and regulations adopted by the Labor Commission of Utah. The RBRVS along with the adopted conversation rates establishes maximum fees determined to be fair compensation to attending physicians and other providers for services.

   The RBRVS schedule is an attempt to set reasonable fees, including usual periods of follow up care, and gives due consideration to the fact that, in general, some cases are more difficult and, some more simplified, and that a specific fee will cover the normal complexity. Fees in excess of scheduled amounts may be in order. However, in extremely complicated or unusual cases, if an additional fee is requested, this should be clearly explained at the time the bill is submitted or arrangements made with the carrier, in advance, where possible. Failure to do so may result in lesser payment.

B. Discounting of the RBRVS

1. Discounting of the RBRVS fees is only allowed when providers have specifically agreed in writing with a payor to have discounts applied to their treatment of injured workers. [See Rule R612-2-5]

C. Medical Care Billing

1. When there is a disagreement as to the fees to be paid, the balance unpaid by the carrier/self-insured employer may <u>not</u> be billed to the patient. Section 34A-2-401, Utah Code Annotated, limits the settlement for such matters to be between the carrier/employer and the health care provider, with <u>no assessment</u> against the employee. It is hoped that providers will not consider the Labor Commission fees to low, and thus, refuse to treat industrially injured/ill patients. If the provider believes modifications to the RBRVS fee schedule are necessary, written recommendations are welcomed and should be made to the Labor Commission of Utah.

2. Physicians can eliminate many questions as to the RBRVS and avoid delay in payment by keeping the carrier informed as to the patient's condition and progress and by providing advance notification of planned hospitalization, surgery or diagnostic testing.

3. Fees will not be approved for services by more than one attending physician over the same period of time, except for services of consultants, anesthetists and assistants, provided such individuals are qualified and it is shown that such services were necessary. The case may require concurrent care by other specialists.

4. In a flat-fee case the carrier is ordinarily liable only for the scheduled fee, even when the case is transferred to another physician. However, exceptions to the rule include:
   (a) First aid or emergency treatment – The first attendant is entitled to reasonable numeration;
   (b) Reasonable payment will also be made, other than proration of the flat fee, when the physician conscientiously and sincerely, using recognized medical procedures for which he is qualified, fails to cure or correct the injury or deformity of the employee.

5. Medical bills should be furnished on the prescribed forms and itemized - particularly showing the dates, nature, and extent of treatment whether for examination, dressings or operations. Separate bills must be presented by each physician, consultant, anesthetist and assistant in order to show the payment was made to the person who rendered services. When assistants are used in surgery, bills will be paid according to the RBRVS in current use by the Utah Labor Commission.

6. Bills for fees should be sent with the final report. Reimbursement cannot be expected until necessary reports have been filed. The operative report and x-ray readings should be automatically submitted along with the billings. This will alleviate the problem of adjusters constantly calling doctors and their staffs for the needed information. Bills should be filed with the carrier/employer only – never the Commission!

7. It is expected that providers in most cases will be able to resolve fee problems with the carrier. It is hoped that only in unusual cases will the assistance of the Labor Commission or the Utah Medical Association be required. It would be expected that the carrier pay all undisputed claims, reserving payment on only that part of the bill in dispute. The carrier should give the provider an explanation for any reduction or rejection of charges and, likewise, the provider should made a concerted effort to bill according to the industrial schedules so as not to create the necessity for reducing and explaining bills continually. The provider should expect that if he/she does not make an effort to bill according to the current RBRVS fee schedule, the carriers/employers cannot afford the time to make such explanations on a routine basis.

8. **As of July 1, 1997, a provider may not take an injured worker to court to collect an unpaid medical bill. The issue must be brought before the Labor Commission.**

VII. MEDICAL PANELS

- The Labor Commission may request a physician to perform an examination of an industrial patient, and his/her medical records, and provide a written report to the Administrative Law Judge adjudicating that patient's claim. Such examinations are done at the expense of the Labor Commission and are known as "Medical Panels."

- Medical Panel members are selected by the Commission. The panel can consist of one or more physicians. The Commission has used panels of orthopeadists, internists, otologists, ophthalmologists, tumor specialists and dermatologists. A panel may not include a physician who has provided treatment to, or had correspondence regarding the patient being examined, but the treating physician is frequently consulted by the panel.

- The Commission pays the member(s) of the panel a fee. The Commission also pays all costs of investigation such as x-ray studies, autopsies, biopsies, laboratory, etc.

- Only the panel members and the injured worker are in attendance at panel meetings. No attorneys are permitted. No member of the Commission will attend.

- The billings for such service should be sent with the reports so that payment can be approved by the Administrative Law Judge and payment made by the Commission. The panel member arranging for the tests, x-rays, etc., should make it clear to the provider of the service that the bills for such are to be sent to the Labor Commission's Division of Adjudication and identified by the name of the employee, the date of injury and the name of the employer. Such bills must also list the federal provider number for payment to be made. The Commission authorizes the level of fees for medical panel members.

VIII. OCCUPATIONAL DISEASES

Occupational diseases are compensable if the occupational disease arose out of and in the course of employment and is medically caused or aggravated by that employment. The physician should file the initial report of the disease with the Labor Commission and the insurance carrier at the time the diagnosis is made.

No disease or injury to health shall be found compensable where it is of a character to which the general public is commonly exposed.

Medical care is provided by carriers in the same manner as for traumatic injuries.

IX. ADJUDICATION PROCESS FOR DISPUTED CLAIMS

- Upon the filing of an "Application for Hearing" (Form 001) for injury by accident, occupational disease, or for death arising out of or in the course of employment, the Labor Commission forwards a copy of such claims to the insurance carrier writing the workers' compensation insurance coverage for the period of time in which the applicant alleges injury.

- The carrier is instructed to answer each allegation presented on the form and file their answer with the Labor Commission within thirty (30) days.

- If the carrier files a denial of liability, the matter is set for hearing before an Administrative Law Judge for the Labor Commission, who takes testimony from both sides.

- If the Administrative Law Judge feels that the record is insufficient as to medical aspects, the case may be referred to a Medical Panel for evaluation. The Medical Panel makes such a study, takes such x-rays and performs such tests (including postmortem examinations upon the authorization of the Labor Commission) as it may determine and, thereafter, makes a report in writing to the Commission on a form prescribed by the Commission. The panel also makes such additional findings as the Commission may require.

- The Commission, upon receipt of the Medical Panel report, mails copies of such report to all parties.

- Those parties have thirty (30) days in which to file any objections to the report.

- If objections are filed, the Administrative Law Judge will ascertain whether or not medical testimony is proffered. If such is proffered, a hearing may be scheduled to take such testimony and to allow for the cross-examination of the Medical Panel chairmen. It is the responsibility of a member of the Medical Panel, usually the chairman, to be present at these hearings.

- Once the report is accepted, the Administrative Law Judge will enter a Findings of Fact, Conclusion of Law and an Order in the matter. Parties then have thirty (30) days in which to file an objection to that Order.

- If objections are received, the Administrative Law Judge, if in agreement, can enter an Amended Order. If the Order is not amended, the entire file and transcript in the case is reviewed by an Appeals Board at the Commission. They subsequently file an Order as to their findings. If objections are received to that Order, either the Commission may amend its Order, or the matter can be filed with the Utah Court of Appeals.

A. Conflicts

Conflicts may relate to medical or non-medical matters.

Non-medical conflicts may revolve around questions of employer-employee relationship, compensability of the alleged accident, levels of benefits, etc. The physician need not be concerned with such questions.

Conflicts that may ultimately involve the physician would revolve around the following:

1. Was the patient disabled from work?
2. When was the patient able to return to work?
3. Was the alleged accident the cause of the problems being treated?
4. Does the patient have a permanent impairment as a result of the problem and, if so, what is the percentage of that impairment?
5. If so, how much is due to a prior impairment that was pre-existing, and if so, should any be apportioned.
6. Were there pre-existing problems? Were they significantly aggravated or changed?

When problems of this nature arise that cannot be resolved mutually by those involved, the injured employee should file an Application for Hearing with the Labor Commission, so that the matter can be adjudicated by an Administrative Law Judge.

X. WORKERS' COMPENSATION RULES

HEALTH CARE PROVIDERS

R612-2. Workers' Compensation Rules – Health Care Providers.

R612-2. Workers' Compensation Rules – Health Care Providers.

R612-2-1. Definitions.

A. All definitions in Rule R612-1 apply to this section.

B. "Medical Practitioner" – means any person trained in the healing arts and licensed by the State in which such person practices.

C. "Global Fee Cases" – are those flat fee cases where fees include pre-operative and follow-up or aftercare.

D. "Usual and Customary Rate" (UCR) – is the rate of payment to a dental provider using Ingenix, or a similar service, for charges for services for a particular zip code.

E. Unless otherwise specified, the term "insurer" includes workers' compensation insurance carriers and self-insured.

R612-2-2. Authority.

This rule is enacted under the authority of Section 34A-1-104.

R612-2-3. Filings.

A Within one week following the initial examination of an industrial patient, nurse practitioner, physicians and chiropractors, shall file Form 123 – "Physicians' Initial Report of Injury/Illness" with the carrier/self -insured employer, employee, and the division. This form is to be completed in as much detail as feasible. Special care

should be used to make sure that the employee's account of how the accident occurred is completely and accurately reported. All questions are to be answered or marked "N/A" if not applicable in each particular instance. All addresses must include city, state, and zip code. If modified employment in #29 is marked "yes" the remarks in #29 must reflect the particular restrictions or limitations that apply, whether as to activity or time per day or both. Estimated time loss must also be given in #29. If "Findings of Examination" (#17) do not correctly reflect the coding used in billing, a reduction of payment may be made to reflect the proper coding. A physician, chiropractor, or nurse practitioner is to report every initial visit for which a bill is generated, including first aid, when a worker reports that an injury or illness is work related. All initial treatment, beyond first aid, that is provide by any health care provider other than a physician, chiropractor, or nurse practitioner must be countersigned by the supervising physician and reported on Form 123 to the Industrial Accidents Division and the insurance carrier or self-insured employer.

B. 1. Any medical provider billing under the restorative services section of the Labor Commission's adopted Resource-Based Relative Value Scale (RBRVS) or the Medical Fee Guidelines shall file the Restorative Services Authorization (RSA Form 221) form with the insurance carrier or self-insured employer (payor) and the division within ten days of the initial evaluation.

2. Upon receipt of the provider's RSA Form 221, the payor has ten days to respond, either authorizing a specified number of visits or denying the request. No more than eight (8) visits may be incurred during the authorization process.

3. After the initial RSA Form 221 is filed with the payor and the division, an updated RSA Form 221 must be filed for approval or denial at least every six visits until a fixed state of recovery has been achieved as evidenced by either subjective or objective findings. If the medical provider has filed the RSA Form 221 form per this rule, the payor is responsible for payment, unless compensability is denied by the payor. In the event the payor denies the entire compensability of a claim, the payor shall so notify the claimant, provider and the division after which the provider may then bill the claimant.

4. Any denial of payment for treatment must be based on a written medical opinion or medical information. The denial notification shall include a copy of the written medical opinion or information from which the denial was based. The payor is not liable for payment of treatment after the provider, claimant, and division have been notified in writing of the denial for authorization to pay for treatment. The claimant may then become responsible for payment.

5. Any dispute regarding authorization or denial for treatment will be determined from the date the division received the RSA Form 221 form or notification of denial for payment of treatment.

6. The claimant may request a hearing before the Division of Adjudication to resolve compensability or treatment issues.

7. Subjective objective assessment plan/procedures (SOAP notes) or progress notes are to be sent to the payor in addition to the RSA Form 221form.

8. **(EFFECTIVE NOVEMBER 1, 1998) Any medical provider billing under the Restorative Services Section of the RBRVS or the Commission's Medical Fee Guidelines who fails to submit the required RSA Form 221 form shall be limited to payment of up to eight visits for a compensable claim. The medical provider may not bill the patient or employer for any remaining balances.**

C. S.O.A.P. notes or progress reports of each visit are to be sent to the payor by all medical practitioners substantiating the care given, the need for further treatment, the date of the next treatment, the progress of the patient, and the expected return-to-work date. These reports must be sent with each bill for the examination and treatment given to receive payment. S.O.A.P. notes are not to be sent to the division unless specifically requested.

D. Form 110 – "Release to Return to Work" must be mailed by either the medical practitioner or carrier/employer to the employee and the division within five calendar days of release.

E. The carrier/employer may request medical reports in addition to regular progress reports. A charge may be made for such additional reports, which charge should accurately reflect the time and effort expended by the physician.

R612-2-4. Hospital or Surgery Pre-authorization.

Any ambulatory surgery or inpatient hospitalization other than a life or limb threatening admission, allegedly related to an industrial injury or occupational disease, shall require pre-authorization by the employer/insurance carrier. Within two working days of telephone request for pre-authorization, the employer/carrier shall notify the physician and employee of approval or denial of the surgery or hospitalization, or that a medical examination or review is going to be obtained. The medical examination/review must be conducted without undue delay, which in most circumstances would have four days from receipt of the request to notify the physician and employee. If the employee chooses to be hospitalized and/or to have the surgery prior to such pre-authorization or medical examination/review, the employee may be personally responsible for the bills incurred and may not be reimbursed for the time lost unless a determination is made in his/her favor.

R612-2-5. Regulation of Medical Practitioner Fees.

A. The Labor Commission of Utah:

1. Establishes and regulates fees and other charges for medical, surgical, nursing, physical and occupational therapy, mental health, chiropractic, naturopathic, and osteopathic services, or any other area of the healing arts as required for the treatment of a work-related injury or illness.
2. Adopts and by this reference incorporates the National Centers for Medicare and Medicaid Services (CMS) for the Medicare Physician Fee Schedule (MPFS) Resource Based Relative Value System @ (RBRVS) 2005 edition, as the method for calculating reimbursement and the American Medical Association's CPT, 2005 edition, coding guidelines. The non-facility total unit value will apply in calculating the reimbursement, except that procedures provided in a facility setting shall be reimbursed at the facility total unit value and the facility may bill a separate facility charge. The CPT-4 coding guidelines and RBRVS are subject to the Utah Labor Commission's Medical Fee Guidelines and Codes and the following Labor Commission conversion factors for medical care rendered for a work-related injury or illness, effective July 2, 2005:

(Conversion Rates below EFFECTIVE July 2, 2005, to be used with the RBRVS procedural Unit value as per specialty.)

Anesthesiology	$41.00 (1 unit per 15 minutes of anesthesia)
Medicine, E & M	$44.00
Restorative Services	$44.00

With Code 97001 and 97003 at 1.5 RVU
With Code 97002 and 97004 at 1.0 RVU

Pathology and Laboratory	150% of Utah's published Medicare carrier
Radiology	$53.00
Surgery	$37.00
All codes (all 20000 and 60000) (49505 through 49525)	$58.00

3. Adopts and incorporates by this reference the Utah Labor Commission's Medical Fee Guidelines and Codes, as of July 2, 2005. The Utah Medical Fee Guidelines and Codes can be obtained from the division for a fee sufficient to recover costs of development, printing and mailing or can be downloaded at the Labor Commission's Web site at www.laborcmmission.utah.gov.
4. Decides appropriate billing procedure codes when disputes arise between the medical practitioner and the employer or his insurance carrier. In no instance will the medical practitioner bill both the employer and the insurance carrier.

B. Employees cannot be billed for treatment of their industrial injuries or occupational diseases.
C. Discounting from the fees established by the Labor Commission is allowed only through specific contracts between a medical provider and a payor for treatment of industrial injured/ill patients.
D. Restocking fee 15%. Rule R612-2-16 covers the restocking fee.
E. Dental fees are not published. Rule R612-2-18 covers dental injuries.
F. Ambulance fees are not published. Rule R612-2-19.

R612-2-6. Fees in Cases Requiring Unusual Treatment.
The RBRVS scheduled fees are maximum fees except that fees higher than scheduled may be authorized by the Commission when extraordinary difficulties encountered by the physician justify increased charges and are documented by written reports.

R612-2-7. Insurance Carrier's Privilege to Examine.
The employer or the employer's insurance carrier or a self-insured employer shall have the privilege of medical examination of an injured employee at any reasonable time. A copy of the medical examination report shall be made available to the Commission at any time upon request of the Commission.

R612-2-8. Who May Attend Industrial Patients.
A. The employer has first choice of physicians; but if the employer fails or refuses to provide medical attention, the employee has the choice of physicians.
B. An employee of an employer with an approved medical program may procure the services of any qualified practitioner for emergency treatment if a physician employed in the program is not available for any reason.

R612-2-9. Changes of Doctors and Hospitals.
A. It shall be the responsibility of the insurance carrier or self-insured employer to notify each claimant of the change of doctor rules. Those rules are as follows:
1. If a company doctor, designated facility or PPO is named, the employee must first treat with that designated provider. The insurance carrier or self-insured employer shall be responsible for payment for the initial visit, less any health insurance copays and subject to any health insurance reimbursement, if the employee was directed to and treated by the employer's or insurance carrier's

designated provider, and liability for the claim is denied and if the treating physician provided treatment in good faith and provided the insurance carrier or self-insured employer a report necessary to make a determination of liability. Diagnostic studies beyond plain X-rays would need prior approval unless the claimed industrial injury or occupational illness required emergency diagnosis and treatment.

2. The employee may make one change of doctor without requesting the permission of the carrier, so long as the carrier is promptly notified of the change by the employee.
   (a) Physician referrals for treatment or consultation shall not be considered a change of doctor.
   (b) Changes from emergency room facilities to private physicians, unless the emergency room is named as the "company doctor," shall not be considered a change of doctor. However, once private physician care has begun, emergency room visits are prohibited except in cases of:
      (i) Private physician referral, or
      (ii) Threat to life.
3. Regardless of prior changes, a change of doctor shall be automatically approved if the treating physician fails or refuses to rate permanent partial impairment.

B. Any changes beyond those listed above made without the permission of the carrier/self-insurer may be at the employee's own expense if:
   1. The employee has received notification of rules, or
   2. A denial of request is made.

C. An injured employee who knowingly continues care after denial of liability by the carrier may be individually responsible for payment. It should be the burden of the carrier to prove that the patient was aware of the denial.

D. It shall be the responsibility of the employee to make the proper filings with the division when changing locale and doctor. Those forms can be obtained from the division.

E Except in special cases where simultaneous attendance by two or more medical care practitioners has been approved by the carrier/employer or the division, or specialized services are being provided the employee by another physician under the supervision and/or by the direct referral of the treating physician, the injured employee may be attended by only one practitioner and fees will not be paid to two practitioners for similar care during the same period.

F. The Commission has jurisdiction to decide liability for medical care allegedly related to an industrial accident.

R612-2-10. One Fee Only to be Paid in Global Fee Cases.

In a global fee case, which is transferred from one doctor to another doctor, one fee only will be paid, apportioned at the discretion of the Commission. Adequate remuneration shall also be paid to the medical practitioner who renders first aid treatment where the circumstances of the case require such treatment.

R612-2-11. Surgical Assistants' Fees.

Fees, in accordance with the Commission's adopted Resource-Based Relative Value Scale (RBRVS), in addition to the global fee for surgical services, will be paid surgical assistants only when specifically authorized by the employer or insurance carrier involved, or in

hospitals where interns and residents are not available and the complexity of the surgery makes a surgical assistant necessary.

R612-2-12. Separate Bills.
Separate bills must be presented by each surgeon, assistant, anesthetist, consultant, hospital, special nurse, or other medical practitioner within 30 days of treatment on a HCFA 1500 billing form so that payment can be made to the medical practitioner who rendered the service. All bills must contain the federal ID number of the person submitting the bill.

R612-2-13. Interest for Medical Services.
A. All hospital and medical bills must be paid promptly on an accepted liability claim. All bills which have been submitted properly on an accepted liability claim, are due and payable within 45 days of being billed unless the bill or a portion of the bill is in dispute. Any portion of the bill not in dispute is payable within 45 days of the billing.
B. Per Section 34A-2-420, any award for medical treatment made by the Commission shall include interest at 8% per annum from the date of billing for the medical service.

R612-2-14. Hospital Fees Separate.
Fees covering hospital care shall be separate from those for professional services and shall not extend beyond the actual necessary hospital care. When it becomes evident that the patient needs no further hospital treatment, he/she must be discharged. All billings must be submitted on a UB92 form and be properly itemized and coded and shall include all appropriate documentation to support the billing. There shall not be a separate fee charged for the necessary documentation in billing for payment of hospital services. The documentation of hospital services shall include at a minimum the discharge summary. The insurance carrier may request further documentation if needed in order to determine liability for the bill.

R612-2-15. Charges for Ordinary Supplies, Materials, or Drugs.
Fees covering ordinary dressing materials or drugs used in treatment shall not be charged separately but shall be included in the amount allowed for office dressings or treatment.

R612-2-16. Charges for Special or Unusual Supplies, Materials, or Drugs.
A. Charges for special or unusual supplies, materials, or drugs not included as a normal and usual part of the service or procedure shall, upon receipt of an itemized and coded bill, be paid at cost plus 15% restocking fees.
B. For purposes of part A above, the amount to be paid shall be calculated as follows:
    1. Applicable shipping charges shall be added to the purchase price of the product.
    2. The 15% restocking fee shall then be added to the amount determined in sub part 1.
    3. The amount of taxes paid on the purchase of the supplies, materials, or drugs shall then be added to the amount determined in sub part 2, which sum shall constitute the total amount to be paid.

R612-2-17. Fees for Unscheduled Procedures.
Fees for medical or surgical procedures not appearing in the Commission's adopted RBRVS current fee schedule are subject to the Commission's approval and should be submitted to the Commission when the physician and employer or insurance carrier do not agree on the value

of the service. Such fees shall be in proportion as nearly as practicable to fees for similar services appearing in the RBRVS.

R612-2-18. Dental Injuries.

A. This rule established procedures to obtain dental care for work-related dental injuries and sets fees for such dental care.

B. Initial Treatment.

1. If an employer maintains a medical staff or designates a company doctor, an injured worker seeking dental treatment for work-related injuries shall report to such medical staff or doctor and follow their instructions.
2. If an employer does not maintain a medical staff or designate a company doctor, or if such staff or doctor are not available, an injured worker may consult a dentist to obtain immediate care dental for injuries caused by a work-related injury.

C. Subsequent care by initial treatment provider.

1. If additional treatment is necessary, the dentist who provided initial treatment may submit to the insurer a request for authorization to continue treatment. The transmission date of the request must be verifiable. The request itself must include a description of the injury, the additional treatment required, and the cost of the additional treatment. If the dentist proceeds with treatment without authorization, the dentist must accept 70% of UCR as payment in full and may not charge any additional sum to the injured worker.
2. The insurer shall respond to the request for authorization within 10 working days of the request's transmission. The 10 day period can be extended only with written approval of the Industrial Accidents Division. If the insurer does not respond to the dentist's request for authorization within 10 working days, the insurer shall pay the cost of treatment as contained in the request for authorization.
3. If the insurer approves the proposed treatment, the insurer shall send written authorization to the dentist and injured worker.
4. On receipt of the insurer's written authorization, and if the dentist accepts the payment provisions therein, the dentist may proceed to provide the approved services. The dentist must accept the amount to be paid by the insurer as full payment for those services and may not bill the injured worker for any additional amount.

D. Subsequent care by other providers.

1. If the dentist who provided initial treatment does not agree to the payment offered by the insurer, the insurer shall within 20 calendar days direct the injured worker to a dentist located within a reasonable travel distance who will accept the insurer's payment offer.
2. If the insurer cannot locate another dentist to provide the necessary services, the insurer shall attempt to negotiate a satisfactory reimbursement with the dentist who provided initial treatment. The negotiated reimbursement may not include any balance billing to the claimant.
3. If the insurer is successful in arranging treatment with another dentist, the insurer shall notify the injured worker.
4. If, after having received notice that the insurer has arranged the services of another dentist, the injured worker chooses to obtain treatment from a different dentist, the insurer shall only be responsible for payment of 70% of UCR. Under the circumstances of this subsection (4), the treatment dentist may bill

the injured worker for the difference between the dentist's charges and the amount paid by the insurer.

E. Payment or treatment disputes that cannot be resolved by the parties may be submitted to the Labor Commission's Adjudication Division for decision, pursuant to the Adjudication Division's established forms and procedures.

R612-2-19. Ambulance Charges.

Ambulance charges must not exceed the rates adopted by the State Emergency Medical Service Commission for similar services.

R612-2-20. Travel Allowance and Per Diem.

A. An employee who, based upon his/her physician's advice, requires hospital, medical, surgical, or consultant services for injuries arising out of and in the course of employment and who is authorized by the self-insurer, the carrier, or the Commission to obtain such services from a physician and/or hospital shall be entitled to:

1. Subsistence expenses of $5 per day for breakfast, $6 per day for lunch, $10 per day for dinner, and actual lodging expenses as per the state of Utah's in-state travel policy provided:
   (a) The employee travels to a community other than his/her own place of residence and the distance from said community and the employee's home prohibits return by 10:00 p.m., and
   (b) the absence from home is necessary at the normal hour for the meal billed.
2. Reasonable travel expenses regardless of distance that are consistent with the state of Utah's travel reimbursement rates, or actual reasonable costs of practical transportation modes above the state's travel reimbursement rates as may be required due to the nature of the disability.

B. This rule applies to all travel to and from medical care with the following restrictions:

1. The carrier is not required to reimburse the injured employee more often than every three months, unless
   (a) More than $100 is involved, or
   (b) the case is about to be closed.
2. All travel must be by the most direct route and to the nearest location where adequate treatment is reasonably available.
3. Travel may not be required between the hours of 10:00 p.m. and 6:00 a.m., unless approved by the Commission.
4. Requests for travel reimbursement must be submitted to the carrier for payment within one year of the authorized medical care.
5. Travel allowance shall not include picking up prescriptions unless documentation is provided substantiating a claim that prescriptions cannot be obtained locally within the injured workers' community.
6. The Commission has jurisdiction to resolve all disputes.

R612-2-21. Notice to Health Care Providers.

Any notice from a carrier denying further liability must be mailed to the Commission and the patient on the same day as it is mailed to the health care provider. Where it can be shown, in fact, that a medical care provider and the injured employee have received a denial of further care by the insurance carrier or self-insured employer, further treatment may be performed at the expense of the employee. Any future ratification of the denial by the Commission will not

be considered a retroactive denial but will serve to uphold the force and effect of the previous denial notice.

R612-2-22. Medical Records.

A. Workers' compensation insurers, employers and the Utah Labor Commission need access to health information of individuals who are injured on the job or who have a work-related illness in order to process or adjudicate claims, or to coordinate care under Utah's workers'compensation system. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by federal HIPAA privacy rules.

The HIPAA Privacy Rule specifically recognizes the legitimate need of the workers' compensation system to have access to individuals' health information to the extent authorized by State law. See 45 CFR 164.512(1). The Privacy Rule also recognizes the importance of permitting disclosures required by other laws. See 45 CFR 164-512(a). Therefore, disclosures permitted by this rule for workers' compensation purposes or otherwise required by this rule do not conflict with and are not prohibited by the HIPAA Privacy Rule.

B. A medical provider, without authorization from the injured workers, shall:

1. For purposes of substantiating a bill submitted for payment or filing required Labor Commission forms, such as the "Physician's Initial Report of Injury/Illness" or the "Restorative Services Authorization," disclose medical records necessary to substantiate the billing, including drug and alcohol testing, to:
   a. An employer's workers' compensation insurance carrier or third party administrator;
   b. A self-insured employer who administers its own workers' compensation claims;
   c. The Uninsured Employers' Fund;
   d. The Employers' Reinsurance Fund; or
   e. The Labor Commission as required by Labor Commission rules.
2. Disclose medical records pertaining to treatment of an injured worker who makes a claim for workers' compensation benefits, to another physician for specialized treatment, to a new treating physician chosen by the claimant, or for a consultation regarding the claimed work related injury or illness.

C. 1. Except as limited in C(3), a medical provider, whose medical records re relevant to a workers' compensation claim shall, upon receipt of a Labor Commission medical records release form, or an authorization form that conforms to HIPAA requirements, disclose his/her medical records to:
   a. An employer's insurance carrier or third party administrator;
   b. A self-insured employer who administers its own workers' compensation claims:
   c. An agent of an entity listed in B(1) (a through e), which includes, but is not limited to a case manager or reviewing physician;
   d. The Uninsured Employers Fund;
   e. The Employers' Reinsurance Fund;
   f. The Labor Commission;
   g. The injured worker;
   h. An injured workers' personal representative;

i. An attorney representing any of the entities listed above in an industrial injury or occupational disease claim.

2. Medical records re relevant to a workers' compensation claim if:
   a. The records were created after the reported date of the accident or onset of the illness for which workers' compensation benefits have been claimed; or
   b. The records were created in the past ten years (15 years if permanent total disability is claimed) and;
      i. There is a specific reason to suspect that the medical condition existed prior to the reported date of the claimed work related injury or illness, or
      ii. the claim is being adjudicated by the Labor Commission.
3. Medical records related to care provided by a psychiatrist, psychologist, obstetrician, or care related to the reproductive organs may not be disclosed by a medical provider unless a claim has been made for a mental condition, a condition related to the reproductive organs, or the claimant has signed a separate, specific release for these records.

D. A medical provider who has treated an injured worker for a work related injury or illness, shall disclose information to an injured workers' employer as to when and what restrictions an injured worker may return to work.

E. Requests for medical records beyond what sections B,D, and D permit require a signed approval by the director, the medical director, or a designated person(s) within the Industrial Accidents Division.

F. A party affected by the decision made by a person in section E may appeal that decision to the Adjudication Division of the Labor Commission.

G. Upon receipt and within the scope of this rule, an injured worker shall provide those entities or person listed in C(1) the names, address, and dates of medical treatment (if known) of the medical providers who have provided medical care within the past 10 years (15 years for Permanent Total Disability claim) except for those medical providers named in C(3). Labor Commission Form 307 "Medical Treatment Provider List" must be used for this purpose. Parties listed in this rule must provide each medical provider identified on Form 307 with a signed authorization for access to medical records. A copy of the signed authorization may be sent to the medical providers listed on Form 307.

H. An injured worker may contest, for good reason, a request for medical records created prior to the reported date of the accident or illness for which the injured worker has made a claim for benefits by filing a complaint with the Labor Commission. Good reasons is defined as the request has gone beyond the scope of this rule or sensitive medical information is contained in a particular medical record.

I. 1. Any party obtaining medical records under authority of this rule may not disclose those medical records, without a valid authorization, except as required by law.
2. An employer may only use medical records obtained under the authority of this rule to:
   a. Pay or adjudicate workers' compensation claims if the employer is self-insured;
   b. To assess and facilitate an injured workers' return to work;
   c. As otherwise authorized by the injured worker.
3. An employer obtaining medical records under authority of this rule must maintain the medical records separately from the employee's personnel file.

J. Any medical records obtained under the authority of this rule to make a determination regarding the acceptance of liability or for treatment of a condition related to a workers' compensation claim shall only be used for workers' compensation purposes and shall not be released, without a signed release by the injured worker or his/her personal representative, to any other party. An employer shall make decisions related only to the workers' compensation claim based on any medical information received under this rule.

K. When any medical provider provides copies of medical records, other than the records required when submitting a bill for payment or as required by the Labor Commission rules, the following charges are presumed reasonable:
   1. A search fee of $15 payable in advance of the search;
   2. Copies at $.50 per page, including copies of microfilm, payable after the records have been prepared and
   3. Actual costs of postage payable after the records have been prepared and sent. Actual cost of postage are deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.
   4. The Labor Commission will release its records per the above charges to parties/entities with a signed and notarized release from the injured worker unless the information is classified and controlled under the Government Records Access and Management Act (GRAMA).

L. No fee shall be charged when the RBRVS or the Commission's Medical Fee Guidelines require specific documentation for a procedure or when medical providers are required to report by statute or rule.

M. An injured worker or his/her personal representative may obtain one copy of each of the following records related to the industrial injury or occupational disease claim, at no cost, when the injured worker or his/her personal representative have signed a form by the Industrial Accidents Division to substantiate his/her illness claim;
   1. History and physical;
   2. Operative reports of surgery;
   3. Hospital discharge summary;
   4. Emergency room records;
   5. Radiological reports;
   6. Specialized test results; and
   7. Physician SOAP notes, progress notes, or specialized reports.
      (a) Alternatively, a summary of the patients records may be made available to the injured worker or his/her personal representative at the discretion of the physician.

R612-2-23. Adjusting Relative Value Schedule (RVS) Codes.

A. When adjusting any medical provider's bill that has billed per the Commission's RBRVS, the adjusting entity shall provide one or more of the following explanations as applies to the down coding when payment is made to the medical provider:
   1. Code 99202, 99203, 99204 or 99205 - the submitted documentation for a new patient did not meet the three key components lacking in the level of history for the code billed.
   2. Code 99202, 99203, 99204 or 99205 – the submitted documentation for a new patient did not meet the three key components lacking in the level of examination for the code billed.
   3. Code 99202, 99203, 99204 or 99205 – the submitted documentation for a new

patient did not meet the three key components lacking in the level of medical decision making for the code billed.

4. Code 99202, 99203, 99204 or 99205 – the submitted documentation for a new patient did not meet the three key components lacking in the level of history and exam for the code billed.
5. Code 99213, 99214 or 99215 – the submitted documentation for an established patient did not meet the two key components lacking in the level of history and exam that the code billed.
6. Code 99213, 99214 or 99215 – the submitted documentation for an established patient did not meet the two key components lacking in the level of history and medical decision making for the code billed.
7. Code 99213, 99214 or 99215 – the submitted documentation for the established patient did not meet the two key components lacking in the level of exam and medical decision making for the code billed.

B. The above explanations may be abbreviated, with a legend provided, to accommodate the space of computerized messages.

R612-2-24. Review of Medical Payments.

A. Health care providers and payors are primarily responsible to resolve disputes over fees for medical services between themselves. However, in some cases it is necessary to submit such disputes to the Division for Resolution. The Commission therefore establishes the following procedure for submission and review of fees for medical services.

1. The provider shall submit a bill for services rendered, with supporting documentations, to the payor within one year of date of service.
2. The payor shall evaluate the bill according to the guidelines contained in the Commission's Medical Fee Guidelines and RBRVS and shall pay the provider the appropriate fee within 45 days as required by Rule 612-2-13.
3. If the provider believes that the payor has improperly computed the fee under the RBRVS, the provider or designee shall request the payor to re-evaluation the fee. The provider's request for re-evaluation shall be in writing, shall describe the specific areas of disagreement, and shall include all appropriate documentation. The provider shall submit all requests for re-evaluation to the payor within one year of the date of the original payment.
4. Within 30 days of receipt of the written request for re-evaluation, the payor shall either pay the additional fee due the provider or respond with a specific written explanation of the basis for its denial of additional fees. The payor shall maintain proof of transmittal of its response.

B. If the provider continues to disagree with the payor's determination of the appropriate fee, the provider shall submit the matter to the Division by filing with the Division a written explanation of the disagreement. The provider's explanation shall include copies of:

1. The provider's original bill and supporting documentation;
2. The payor's initial payment of that bill;
3. The provider's request for re-evaluation and supporting documentation; and
4. The payor's written explanation or its denial of additional fees.

C. The Division will evaluate the dispute according to the requirements of the Medical Fee Guidelines and RBRVS and, if necessary, by consulting with the provider, payor, or medical specialists. Within 45 days from the date the Division receives the provider's request, the Division will mail its determination to both parties.

D. Any party aggrieved by the Division's determination may file an application for haring with the Division of Adjudication to obtain formal adjudication of the dispute.

E. A payor seeking reimbursement from a provider for overpayment of a bill shall submit a written request to the provider detailing the circumstances of the payment requested within one year of submission of the bill.

1. Providers should make appropriate reimbursements, or respond in writing detailing the reasons why repayment will not be made, within 90 days or receipt of a written request from a payor.
2. If a dispute as to reimbursement occurs, an aggrieved party may request resolution of the dispute by the Labor Commission.

R612-2-25. Injured Worker's Right to Privacy.

A. No agent of the employer or the employer' insurance carrier shall be present during an injured worker's visit with a medical provider, unless agreed upon by the claimant.

B. If an agent of the employer or the employer's insurance carrier is excluded from the medical visit, the medical provider and the insured worker shall meet with the agent at the conclusion of the visit so as to communicate regarding medical care and return to work issues.

R612-2-26. Utilization Review Standards.

A. As used in this subsection.

1. "Payor" means a workers' compensation insurance carrier, a self-insured employer, third-part administrator, uninsured employer or the Uninsured Employers' Fund, which is responsible for payment of the workers' compensation claim.
2. "Health Care Provider" means a provider of medical services, including an individual povider, a health-service plan, a health care organization, or a preferred provider organization.
3. "Request for Authorization" means any request by a physician for assurance that appropriate payment will be made for a course of proposed medical treatment, including surgery or hospitalization, or any diagnostic studies beyond plain X-rays.
4. "Utilization Review" as authorized in Section 34A-2-111, is a process used to manage medical costs, improve patient care, and enhance decision-making. Utilization review includes, but is not limited to, the review of requests for authorization to treat, and the review of bills, for the purpose of determining whether the medical services provided were or would be necessary, to treat the effects of the injury/illness. Utilization review does not include bill review for the purpose of determining whether the medical services rendered were accurately billed. Nor does it include any system, program, or activity in connection with making decisions concerning whether a person has sustained an injury or illness that is compensable under Section 34A-2 or 34A-3.
5. "Reasonable Attempt" is defined as at least two phone calls and a fax, or three phone calls within five business days from date of the payor's receipt of the physician's request for review.

B. Any utilization review system shall establish an appeals process, which utilizes a physician(s) for a final decision by the insurer, should an initial review decision be contested. The payor may establish levels of review that meet the following criteria:

1. Level I—Initial Request and Review. A payor may use medical or non-medical personnel to initially apply medically-based criteria to a request for

authorization for payment of a specific treatment. The treating physician must send all the necessary documentation for the payor to make a decision regarding the treatment recommended. The payor must then notify the physician within five business days of the request for authorization of payment for the treatment, by a method that provides certification of transmission of the document, of either an acceptance or a denial of the request. **A denial for authorization of payment for a recommended treatment, utilizing the Commission's Form 223, must be sent to the provider with the criteria used in making the determination to deny payment for the treatment.** A copy of the denial must also be mailed to the claimant. Level I—Request and Review does not include authorization requests for services billed from the Restorative section of the Resource-Based Relative Value Schedule (RBRVS). Requests for authorization for restorative services are governed by rule $612-2-3(B).

2. Level II—Review. **A physician, who has been denied authorization of payment for treatment, or has received no response within five business days from the request for authorization for payment at Level I review, may request a physician's review by sending the completed portion of the Commission form 223 to the payor.** Such a request for review may be filed by any physician who has been denied authorization for payment for restorative services beyond the initial eight visits as authorized by Rule R612-2-3(B). The requesting physician must include the times and days that he/she is available to discuss the case with the reviewing physician, and must be reasonably available during normal business hours. The payor's physician representative must complete the review within five days of the treating physician's request for review. Before the insurer's physician representative may issue a denial of an authorization for payment to treat, a reasonable effort must have made to contact the requesting treating physician to discuss the differing aspects of the case. Failure by the payor to respond within five business days, by a method that provides certification of transmission, to a denial for authorization for payment for treatment, shall constitute an authorization for payment of the treatment. The payor's denial to pay for the recommended treatment must be issued on Commission's form 223, and the denial must be accompanied by the criteria that was used in making the decision to deny authorization along with the name and specialty of the reviewing physician. The denial to authorize payment for treatment must then be sent to the physician, the claimant, and the Commission. The payor shall notify the Commission if an additional five days is needed in order to contact the treating physician or to review the case. An additional extension of time may be requested from the Commission to accommodate highly unusual circumstances or particularly difficult cases.

C Upon receipt of denial of authorization for payment for medical treatment at Level II, the Commission will facilitate, upon the request of the claimant, the final disposition of the case. If the parties agree, the medical dispute may be resolved by the Commission through binding mediation or medical review. If there is not agreement among the parties, the Commission will resolve the dispute through formal adjudication. The payor shall be responsible for sending the claimant the Commission appeals information when the denial for authorization for payment for medical treatment is sent to the claimant.

D. If the medical treatment requested is not an emergency, and treatment is rendered by the physician after receiving notice of the utilization standards encompassed in this rule, the following shall apply.

1. The Commission shall, if the disputed medical treatment is ultimately determined to be compensable as an expense necessary to treat the industrial injury or occupational disease, order that the physician be reimbursed at only 75% of the amount otherwise payable had appropriate authorization been timely obtained. The injured worker shall not be liable for any additional payment to the physician above the 75%.
2. Neither the worker's employer or its workers' compensation insurer shall be l liable for any portion of the cost of disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat an industrial injury or occupational disease.
3. A worker may become liable for the cost of the disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat the industrial injury or occupational disease.
4. Except for any co-pays or deductibles under the worker's health insurance plan, the penalty provision in D(1) and D-(3) shall not apply if the physician performs the medical treatment in question, having been preauthorized in writing to do the same by a health insurer or other non-worker's compensation insurance payor.
5. The penalty provisions in D(1) shall not apply to medical treatment rendered in emergency situations, which are defined as a threat to life or limb.
6. The Commission shall notify a physician, in writing, of reported violations of this rule. Repeated violations of this rule by a physician may result in a report from the Commission to the Department of Commerce, Division of Occupational/Professional Licensing.

LABOR COMMISSION

MEDICAL REPORTING FORMS

THE FOLLOWING MEDICAL REPORTING FORMS FOLLOW THIS PAGE

1. "Physician's Initial Report of Work Injury or Occupational Disease" – Form 123
2. "Restorative Services Authorization/Denial" – Form 221
3. "Release to Return to Work" – Form 110
4. "Application to Change Doctors" – Form 102
5. "Authorization Request for Medical Procedures / Carrier Response – Form 223
6. "Attending Physician's Statement" – Form 403
   "Employee's Notification of Intent to Leave Locality or State, and to Change Doctor or Hospital" – Form 044